MAP-9 (Rev. 02/05)

COMMONWEALTH OF KENTUCKY
Cabinet for Health & Family Services
KENTUCKY MEDICAID PROGRAM
PRIOR AUTHORIZATION FOR HEALTH-SERVICES

1. Med. Assist. I.D. No. (Ten Digits)	2. Recipient Last Name:	3. First Name:	4. M.I.
5a: Provider Number (Eight Digits)	6a. Provider Name, Address, and Phone Number	7. Co. # of Recipient Residence:	
5b. Provider Number (Eight Digits)	6b. Provider Name, Address, and Phone Number	8. Date of Delivery (if already delivered)	

9. Primary Diagnosis:

10. Secondary Diagnosis:

11. Date of Birth ___ ___ _____ MM DD YYYY

Signature of Provider:

Date:

Caution: In order for you to receive payment, the recipient must be eligible on the date of service.

Check The Medicaid Card.

12. Line No.	13. Procedure/Supply Description	14. Procedure Supply Code	15. Units of Service	16. Usual and Customary Charges	17. Medicaid Action A=Approved D=Disapproved	18. Approved Amount*
01.						
02.						
03.						
04.						
05.						
06.						

19. HCB and Model Waiver Providers enter Approximate Total Monthly Charge:

$_____

DO NOT WRITE BELOW THIS LINE

20. Reason for Denial:

21. Other Comments:

22. Prior Authorization Number:

Mailroom Use:

*Not used by H.C.B. Waiver/Model Waiver

23. Approval Dates:

From: _____

Through: _____

24. Type of Service Authorized:

40_____DME
41_____MODEL WAIVER
45_____EPSDT/SPECIAL SERVICE
46_____HOME HEALTH
52_____H.C.B.
52&53_____H.C.B. & A.D.C.
72_____DENTAL
_____OTHER

Signature of Medicaid/Prior Authorization Representative:

Date: